114.1 CMR 36.00: ACUTE CARE HOSPITAL CHARGES AND RATES OF PAYMENT FOR CERTAIN PUBLICLY ASSISTED INDIVIDUALS

Section

36.01: General Provisions

(1) Scope, Purpose, and Effective Date.

(a) 114.1 CMR 36.00 implements the provisions of M.G.L. 118G regarding acute hospitals.

(b) 114.1 CMR 36.00 sets forth the methods used to determine reasonable financial requirements of Disproportionate Share Hospitals as defined in M.G.L. 118G, § 1, and governs the Title XIX rates of payment effective October 1, 2005 for Disproportionate Share Hospitals, emergency services not covered by an agreement with EOHHS pursuant to the Acute Hospital Request for Applications, and Sole Community Providers.

(2) Authority. 114.1 CMR 36.00 is adopted pursuant to M.G.L. 118G.

(3) Disclaimer of Authorization of Services. 114.1 CMR 36.00 is neither authorization for nor approval of the substantive services for which rates are determined pursuant to 114.1 CMR 36.00. Governmental units that purchase services from eligible providers are responsible for the definition, authorization, and approval of services extended to publicly assisted clients.

(4) Overview. The Medicaid rates established in 114.1 CMR 36.05 and 114.1 CMR 36.06 do not apply to the following:
   (a) mental health and substance abuse services payable by EOHHS's Behavioral Health (BH) contractor;
   (b) services provided to Medicaid patients enrolled in managed care organizations;
   (c) air ambulance services;
   (d) hospital services paid through other contracts or regulations; or,
   (e) non-acute services in acute hospitals, except as noted in 114.1 CMR 36.05(8).

36.02: Definitions

Acute Hospital. A hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Administrative Day (AD). A day of inpatient hospitalization on which a member's care needs can be provided in a setting other than an acute hospital, and on which the member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416.

Administrative Day Per Diem. An all-inclusive per diem payable to hospitals for administrative days.

Ambulatory Patient Group (APG). A group of outpatient services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation's APG version 2.0 Grouper.

Ambulatory Payment Group Payment System (APG Payment System). The payment system described in MassHealth's Acute Hospital RFA and Contract effective February 1, 2002.

Average APG Weight Per Episode. An index of resources used, on average, in the PAPE base year to treat a MassHealth Member in the hospital outpatient department or Satellite Clinic, as measured by the APG Payment System weights based on Total APG Payment.

Behavioral Health (BH) Contractor. The entity with which EOHHS contracts to provide Behavioral Health Services to enrolled Members.

Behavioral Health Services. Services provided to Members who are being treated for psychiatric disorders or substance-related disorders.

Casemix. The description and categorization of a hospital's patient population according to criteria approved by the Division including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

Centers for Medicare and Medicaid Services (CMS). The federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

Charge. The uniform price for each specific service within a revenue center of an acute hospital.

Clinical Laboratory Service. Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy (DHCFP).

Community-Based Entity. Any entity that is not a hospital-based entity.

Community-Based Physician. Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

Comprehensive Cancer Center. The hospital of any institution so designated by the national cancer institute under the authority of 42 USC §§ 408(a) and 408(b) organized solely for the treatment of cancer, and offered exemption from the Medicare diagnosis related group payment system under 42 CFR 405.475(f).

Disproportionate Share Hospital. Any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act, other government payers and free care. See M.G.L. 118G, § 1.

Division. The Division of Health Care Finance and Policy (DHCFP).

Early Maternity Discharge. A discharge from inpatient care less than 48 hours after a vaginal delivery and less than 96 hours after a caesarean delivery.

Emergency Department (E.D.). A hospital’s Emergency Room or Level I Trauma Center that is located at the same site as the hospital’s inpatient department.

Emergency Medical Condition. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a Member or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services. Covered inpatient and outpatient services, including behavioral health services, that are furnished to a Member by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize a Member's emergency medical condition.

Episode. All outpatient services, except those described in 114.1 CMR 36.06 (2) (f), delivered to a MassHealth Member where the services were delivered on a single calendar day.

Episode Cost. A hospital's cost for delivering an episode of care as determined by MassHealth. Episode Cost is the product of the hospital's charges for those claim lines of an episode that adjudicate to pay and the outpatient cost-to-charge ratio as calculated by DHCFP.

Excluded Units. Non-acute units as defined in 114.1 CMR 36.02; any unit which has a separate license from the Hospital; psychiatric and substance abuse units; and non-distinct observation units.

Executive Office of Health and Human Services (EOHHS). The single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Governmental Unit. The Commonwealth or any department, agency board, commission, or political subdivision of the Commonwealth.

Gross Patient Service Revenue. The total dollar amount of a hospital's charges for services rendered in a fiscal year.

Hospital. See Acute Hospital.

Hospital-Based Entity. Any entity that contracts with a hospital to provide hospital services to Members at a site for which the Hospital is otherwise eligible for payment under the RFA.

Hospital-Based Physician. Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide hospital services to Members at a site for which the Hospital is otherwise eligible for payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, and physician assistants are not hospital-based physicians.

Hospital-Licensed Health Center (HLHC). A Satellite Clinic that (1) meets MassHealth requirements for payment as an HLHC as provided at 130 CMR 410.413; and (2) is approved by and enrolled with the MassHealth's Provider Enrollment Unit as an HLHC.

Inpatient Admission. The admission of a Member to an acute hospital for the purposes of receiving inpatient services in that hospital.

Managed Care Organization (MCO). Any entity with which EOHHS contracts to provide primary care and certain other medical services, including behavioral health services, to Members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) or that otherwise meets the state plan definition of an HMO.

MassHealth (also Medicaid). The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Title XIX and XXI of the Social Security Act, and any approved waivers of such provisions.

Member. A person determined by the EOHHS to be eligible for medical assistance under the MassHealth program.

Non-Acute Unit. A chronic care, rehabilitation, or skilled nursing facility within a hospital.

Outlier Day. Each day beyond 20 acute days, during a single admission, for which a Member remains hospitalized at acute status, other than in a DMH-licensed bed.

Outpatient Department (also Hospital Outpatient Department). A department or unit located at the same site as the hospital's inpatient facility, or a School-Based Health Center that operates under the hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, primary care clinics, specialty clinics, and EDs.

Outpatient Services (also Outpatient Hospital Services). Medical services, including behavioral health services, provided to a Member on an outpatient basis, by or under the direction of a physician or dentist, in a hospital outpatient department, or satellite clinic for which a payment method is specified in 114.1 CMR 36.00. Such services include, but are not limited to, emergency services, primary care services, observation services, ancillary services, and day surgery services.

Payment Amount Per Episode (PAPE). The hospital-specific payment for all PAPE-covered services provided by a hospital to a MassHealth Member on an outpatient basis in one episode.

PAPE-Covered Services. MassHealth-covered services provided by hospital outpatient departments or Satellite Clinics, except those services described in 114.1 CMR 36.06 (2) (f).

PPS-Exempt Hospitals. Those hospitals excluded from the Medicare outpatient prospective payment system as of December 31, 2005.

Projected Average APG Weight Per Episode. The hospital-specific average of the projected APG weights per episode for RY 06. The projected monthly average APG payments are the result of projecting the trend of statistically smoothed monthly average APG weights from January 2001-September 2004 through September 2006.

Pass-Through Costs. Organ acquisition, malpractice, and direct medical education costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount per discharge.

Patient. A person receiving health care services from a hospital.

Pediatric Specialty Hospital. A hospital licensed in Massachusetts under M.G.L. c. 111, §51, that limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit. A pediatric unit in an acute hospital which maintains a level 1 burn and trauma center for pediatrics, or in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20, unless located in a facility already designated as a specialty hospital.

Primary Care. All health care and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or nurse practitioner, to the extent the furnishing of those services is legally authorized in the Commonwealth.

Private Sector Charges. Gross patient service revenues attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other publicly-aided patients, free care, and bad debt.

Provider. An individual or entity that has a written contract with EOHHS to provide medical goods or services to Members.

Public Service Hospital. Any public acute hospital or any acute hospital operating pursuant to St. 1995, c. 147, that has a private sector payer mix that constitutes less than 35% of its Gross Patient Service Revenue (GPSR) and where uncompensated care comprises more than 20% of its GPSR.

Purchaser. A person responsible for payment for health care services rendered by a hospital.

Rate Year (RY). Generally, the period beginning October 1 and ending the following September 30. RY06 will begin on October 1, 2005 and end on September 30, 2006.

Request for Applications (RFA). The contract between EOHHS and eligible, in-state hospitals that governs the hospital's participation as a Massachusetts MassHealth Provider.

Revenue Center. A functioning unit of a hospital that provides distinctive services to a patient for a charge.

Satellite Clinic. A facility that: (1) operates under a hospital's license; (2) is subject to the fiscal, administrative, and clinical management of that hospital; (3) provides services to Members solely on an outpatient basis; (4) is not located at the same site as the hospital's inpatient facility; and, (5) demonstrates to EOHHS's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

School-Based Health Center (SBHC). A center located in a school setting that: (1) provides health services to MassHealth Members under the age of 21; (2) operates under a hospital's license; (3) is subject to the fiscal, administrative, and clinical management of a hospital outpatient department or HLHC; and, (4) provides services to Members solely on an outpatient basis.

Sole Community Hospital. Any acute hospital classified as a sole community hospital by CMS Medicare regulations; or any hospital that demonstrates to the Division's satisfaction that it is located more than 25 miles from other acute hospitals in the Commonwealth and that it provides services for at least 60 percent of its primary service area; or any such hospital as otherwise defined in M.G.L. c. 118G.

Specialty Hospital. Any acute hospital that limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer.

State Institution. Any hospital, sanatorium, infirmary, clinic or other such facility that is owned, operated, or administered by the Commonwealth, that furnishes general health supplies, care or rehabilitative services and accommodations.

Title XIX. Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., or any successor statute enacted into federal law for the same purposes as Title XIX.

Transfer Patient. Any inpatient who meets any of the following criteria: (1) is transferred between acute hospitals; (2) is transferred between a DMH-licensed bed and a medical/surgical unit in an acute hospital; (3) is receiving treatment for a substance-related disorder or mental health-related services and whose enrollment status with the BH Contractor changes; (4) who becomes eligible for MassHealth after the date of admission and prior to the date of discharge; (5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge; (6) who transfers, after the date of admission, from the PCC Plan or non-managed care to an MCO, or from an MCO to the PCC Plan or non-managed care; or, (7) has a primary diagnosis of a psychiatric disorder in a non-DMH-licensed bed.

Usual and Customary Charge. Routine fees that hospitals charge for acute inpatient and outpatient services, regardless of payer source.

36:03: Freedom to Contract and to Modify Charges

(1) Charge Modifications. Charge modifications implemented by acute care hospitals are not subject to prior approval by the Division. Any acute hospital that makes a charge or accepts a payment based upon a charge in excess of that filed with the Division shall be subject to penalties pursuant to 114.1 CMR 36.16.

(2) Freedom to Contract. Acute care hospitals may enter into contractual arrangements with purchasers and third party payers. No such arrangement, including but not limited to prices or charges which may be charged for non-contracted services or which may be negotiated in individual contracts between such acute care hospitals and such purchasers or third party payers, shall be subject to prior approval by the Division; provided, however, that charges established by an acute hospital for health care services rendered shall be uniform for all patients receiving comparable services.

36.04: Determination of Disproportionate Share Status under M.G.L. 118G

(1) Criteria for Determination of Disproportionate Share Status. The Division will determine the percentage of each hospital's gross patient service revenue (GPSR) attributable to Medicare, Medicaid, other governmental payers, and free care, using the data sources described in 114.1 CMR 36.04(2). If this percentage is greater than or equal to 63%, the hospital qualifies as a disproportionate share hospital.

(2) Data Sources for Determination of Disproportionate Share Status.

(a) For FY96 and thereafter, the Division will use the most recent submission of the hospital's DHCFP-403 Cost Report to obtain charges attributable to Medicare, Medicaid, other government payers, and total charges.

(b) The Division will obtain free care charge data from the hospital's UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).

(c) For the purposes of determining disproportionate share status, the Division will include Medicare managed care GPSR as Medicare GPSR, and Medicaid managed care GPSR as Medicaid GPSR.

36.05: Determination of Medicaid Inpatient Payment Rates for Disproportionate Share Hospitals and Sole Community Hospitals

(1) Overview.

(a) Applicability. Except as otherwise provided in 114.1 CMR 36.01(4), 114.1 CMR 36.05 establishes Medicaid inpatient rates of payment to acute care hospitals that qualify for disproportionate share status and sole community hospitals under M.G.L. 118G and that enter into an agreement with EOHHS for provision of acute hospital services to MassHealth members pursuant to the Acute Hospital Request for Applications. The Division determines eligibility for disproportionate share status pursuant to 114.1 CMR 36.04.

(b) Effective date. Unless as otherwise noted, 114.1 CMR 36.05 governs Medicaid rates for services provided from October 1, 2005 through September 30, 2006. Rates for patients whose acute inpatient stay spans two different fiscal years shall be those rates in effect on the date of the patient's admission.

(2) Rates of Payment for Inpatient Services

(a) Overview. Except as otherwise provided in 114.1 CMR 36.01(4), 114.1 CMR 36.05 establishes the methodology for determining Medicaid rates of payment for covered inpatient services. The Medicaid rate of payment for covered inpatient services consists of a single hospital-specific standard payment amount per discharge (SPAD). This hospital-specific payment amount equals the sum of:

1. a statewide average payment amount per discharge;
2. a pass-through payment amount per discharge for malpractice, organ acquisition, and direct medical education costs; and,
3. a capital payment amount per discharge.

(b) Standard Payment Amount per Discharge (SPAD). The standard payment amount per discharge for each hospital is derived by multiplying the RY06 statewide average payment amount per discharge of $3,742.46 by each hospital's MassHealth casemix index adjusted for outlier acuity and the Massachusetts specific wage area index. To develop the Hospital's RY06 casemix index, EOHHS used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of May 25, 2005, for the period October 1, 2003, through September 30, 2004, which was then matched with the MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations.

(c) Calculation of the Pass-Through Amount Per Discharge. The pass-through amount per discharge is the product of the per diem costs of inpatient malpractice, organ acquisition, and medical education costs and the hospital-specific Medicaid average length of stay from casemix data, excluding such costs related to services in excluded units.

The per diem malpractice cost is net of malpractice costs associated with services in excluded units. The days used in the denominator are also net of days associated with such units. The pass-through amount per discharge is derived from the FY04 DHCFP-403 cost report, as screened and updated as of July 22, 2005. Direct medical education costs will be subject to a primary care training incentive adjustment. The inpatient portion of direct medical education costs is derived from the FY04 DHCFP-403 Report as screened and updated as of July 22, 2005. The amount is calculated by dividing the hospital's inpatient portion of expenses, excluding such expenses related to services in excluded units, by the number of total inpatient days, also net of days associated with excluded units. This per diem amount is then multiplied by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. An incentive of 33% was added to the per discharge cost of primary care training, and a discount of 20% was subtracted from the per discharge cost of specialty care training, provided, however, that the 20% reduction was not applied to the costs of

specialty care resident training at Pediatric Specialty hospitals and Pediatric Specialty Units. For the purposes of this provision, Primary Care resident training is training in internal medicine for general practice, family practice, OB/GYN, and pediatrics. Direct medical education costs are subject to audit by the EOHHS and/or DHCFP.

(d) Capital Payment Amount Per Discharge. The RY06 statewide weighted average capital cost per discharge is $369.88. The hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the hospital's RY06 MassHealth casemix index.

If a Hospital's RY05 capital payment per discharge is greater than its RY06 capital payment per discharge as calculated above and adjusted for inflation and casemix, and the Hospital otherwise qualifies for payment pursuant to 114.1 CMR 36.05(7), the Hospital's RY06 capital payment will equal the Hospital's incurred capital costs, capped at twice the statewide weighted average capital cost per discharge.

(e) Admissions following an outpatient surgery or procedure. If a patient who requires hospital inpatient services is admitted following an outpatient surgery or procedure, the hospital shall be paid at the transfer per diem rate up to the hospital specific SPAD.

(f) Payments for newly-eligible members or in the event of exhaustion of other insurance. When a patient becomes newly Medicaid-eligible or if they become eligible because other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay is paid using the transfer per diem payment, established according to 114.1 CMR 36.05(4), up to the hospital-specific per discharge amount. If the patient is at administrative day status (AD), payment will be made at the AD per diem, as established in 114.1 CMR 36.05(5).

(g) Rate of payment for physician services. For physician services provided by hospital-based physicians or hospital-based entities to MassHealth patients, the hospital will be paid for the professional component of physician services in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 *et seq*. Such payment is at the lower of the fee in the most current promulgation of DHCFP fees as established in 114.3 CMR 16.00, 17.00, 18.00 and 20.00 (including the applicable facility fee for all services where such facility fee has been established), or the hospital's usual and customary charge or 100% of the hospital's actual charge submitted.

Hospitals will be paid for such physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are paid through the DME portion of the SPAD, and, as such, are not paid separately.

Hospitals shall not be paid for inpatient physician services provided by community-based physicians or entities.

(h) Maternity/Newborn rates. Delivery-related maternity cases are paid on the standard payment amount per discharge (SPAD) basis with one SPAD paid for the mother and one SPAD paid for the newborn. The rate includes payment for all services, except physician services, provided in conjunction with a maternity stay.

(3) Outlier rates of payment.

(a) Outlier Per Diem. A hospital qualifies for an outlier per diem payment equal to 60% of the hospital's transfer per diem in addition to the hospital-specific standard payment amount per discharge or transfer per diem payment if all of the following conditions are met: (1) the Medicaid non-managed care length of stay for the hospitalization exceeds 20 cumulative acute days at that hospital (not including days in a DMH-licensed bed or days paid by a third party); (2) the hospital continues to fulfill its discharge planning duties as required in EOHHS regulations; (3) the patient continues to need acute level care and is therefore not on Administrative Day status on any day for which an outlier payment is claimed; (4) the patient is not a patient in a DMH-licensed bed on any day for which an outlier payment is claimed; and, (5) the patient is not a patient in an Excluded Unit within an Acute Hospital.

(b) Pediatric Outlier Payment. In accordance with 42 U.S.C. 1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to acute hospitals for inpatient services involving exceptionally high costs or exceptionally long lengths of stay furnished to children more than one year of age and less than six years of age. Only hospitals that are eligible for Basic Safety Net Care Payments per 114.1 CMR 36.07(3) are eligible for the pediatric outlier payment. The Pediatric Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on EOHHS's Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

a. Exceptionally long lengths of stay: First, a statewide weighted average Medicaid inpatient length of stay is calculated. This is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of Medicaid discharges for all acute care hospitals in the state. Second, the statewide weighted standard deviation for Medicaid inpatient length of stay is calculated. Third, the statewide weighted standard deviation for Medicaid inpatient length of stay is multiplied by two and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

b. Exceptionally high cost. Exceptionally high cost is calculated for hospitals providing services to children greater than one year of age and less than six years of age by the Division as follows:

1. First, the average cost per Medicaid inpatient discharge for each hospital is calculated.

2. Second, the standard deviation for the cost per Medicaid inpatient discharge for each hospital is calculated.

3. Third, the hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two and added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. Eligibility for a Pediatric Outlier Payment. For hospitals providing services to children greater than one year of age and under six years of age, the Division calculates the following:

1. the average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.a., then the hospital is eligible for a Pediatric Outlier Payment.

2. the cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.b., then the hospital is eligible for a Pediatric Outlier Payment.

3. Payment to Hospitals. Hospitals qualifying for an outlier adjustment in the payment amount pursuant to 114.1 CMR 36.05, receive 1/2% of the total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e). The total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e) are reduced by the payment amount under 114.1 CMR 36.05(3)(c).

(c) Infant Outlier Payment. In accordance with 42 U.S.C. 1396a(s), EOHHS will make an annual infant outlier payment adjustment to acute hospitals for inpatient services involving exceptionally high costs or exceptionally long lengths of stay furnished to infants under one year of age. The Infant Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on EOHHS's Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

a. Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of Medicaid discharges for all acute care hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average

Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

b. Exceptionally High Cost is calculated for hospitals providing services to infants under one year of age by the Division as follows:

1. First, the average cost per Medicaid inpatient case for each hospital is calculated;

2. Second, the standard deviation for the cost per Medicaid inpatient case for each hospital is calculated;

3. Third, the hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two, and that amount is added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. For each hospital providing services to infants under one year of age, the Division determines first, the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(d)2.a., then the hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants under one year of age is calculated. If a hospital has a Medicaid inpatient case with a cost that equals or exceeds the hospital's own threshold defined in 114.1 CMR 36.05(3)(d)2.b. above, then the hospital is eligible for an infant outlier payment.

d. Payment to Hospitals. Annually, each hospital that qualifies for an outlier adjustment receives an equal portion of $50,000. For example, if two hospitals qualify for an outlier adjustment, each receives $25,000.

(4) Rates of payment for transfer patients. The text contained in 114.1 CMR 36.05(4) sets forth the payment rates applicable to transferred patients. Purchasing governmental units are responsible for the definition, authorization and approval of transfer services.

(a) Transfers between hospitals.

1. In general, the hospital that is receiving the patient will be paid on a per-discharge basis in accordance with the methodology specified in 114.1 CMR 36.05(2), if the patient is actually discharged from that hospital. This includes when a patient is transferred back and is subsequently discharged from the original hospital. If the patient is transferred to another hospital, then the transferring hospital will be paid at the hospital-specific transfer per diem rate capped at the hospital-specific SPAD. Additionally, "back transferring" hospitals (hospitals to which a patient is first admitted and then transferred back after having been transferred to another acute hospital) will be eligible for outlier payments specified in 114.1 CMR 36.05(3).

2. Except as otherwise provided in the following paragraph, the RY06 payment per day for transfer patients shall equal the statewide average payment amount per discharge divided by the SPAD base year average all-payer length of stay of 4.48 days, to which is added the hospital-specific capital, direct medical education and pass-through per diem payments which are derived by dividing the per-discharge amount for each of these components by the hospital specific MassHealth average length of stay.

   For hospitals with unique circumstances as provided in 114.1 CMR 36.05(7), the RY06 payment amount per day for Transfer Patients shall equal the individual hospital's standard inpatient payment amount per discharge divided by the FY03 average all-payer length of stay of 4.48 days, to which is added the hospital-specific capital, direct medical education and pass-through per diem payments which are derived by dividing the per-discharge amount for each of these components by the hospital specific MassHealth average length of stay.

   For hospitals with unique circumstances, the transfer per diem as calculated above will be increased by multiplying the hospital-specific transfer per diem by 1.25.

(b) Transfers within a hospital. In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be paid on a transfer per diem basis capped at the hospital-specific SPAD. This section outlines payment policy under some specific transfer circumstances.

1. Transfer to/from a non-acute, skilled nursing, or separately licensed unit within the same hospital. If a patient is transferred from an acute bed to a non-acute, skilled nursing, or separately licensed unit in the same hospital, the transfer is considered a discharge. EOHHS will pay the hospital-specific SPAD for the portion of the stay before the patient is discharged to any such unit.
2. MassHealth payments for newly-eligible Members, Members who change enrollment in the PCC plan, fee for service or MCO during a hospital stay; or, in the event of exhaustion of other insurance. When a patient becomes MassHealth-eligible, enrolls in or disenrolls from an MCO during the course of a hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the transfer per diem rate, up to the hospital-specific SPAD, or, if the patient is at the Administrative Day (AD) level of care, at the AD per diem rate. When a patient enrolls in or disenrolls from an MCO during the hospital stay, the non-MCO days will be paid at the transfer per diem rate up to the SPAD.
3. Admissions following Outpatient Surgery or Procedure. If a patient who requires inpatient hospital services is admitted following an

outpatient surgery or procedure, the Hospital shall be paid at the transfer per diem rate up to the Hospital-specific SPAD.

4. Transfer between a DMH-licensed bed and any other bed within the same hospital. Payment for a transfer between a DMH-licensed bed and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, BH network or non-network hospital, or the type of service provided. Refer to subsections (5)(a) and (b) below.
5. Change of BH managed care status during a behavioral health hospitalization.
   (a) Payments to hospitals without network provider agreements with EOHHS's BH Contractor. When a Member is enrolled with the BH Contractor during a non-emergency or emergency behavioral health admission at a non-network hospital, the portion of the hospital stay during which the Member is enrolled with the BH Contractor shall be paid by the BH Contractor provided that the hospital complies with the BH Contractor's service authorization and billing policies and procedures. If the BH Contractor offers to pay the Hospital at the RFA transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services, and at the psychiatric per diem rate, capped at the hospital-specific SPAD for psychiatric services under these circumstances, the hospital must accept the BH Contractor's rate offer for all such Members. This requirement does not prohibit the BH Contractor from choosing to pay at a rate higher or lower for all such services provided. The portion of the hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-licensed bed or at the transfer per diem rate for substance-related disorder services and for psychiatric services in a non-DMH-licensed bed, capped at the Hospital-specific SPAD.
   (b) Payments to hospitals that are in the BH Contractor's Network. When a Member is enrolled with the BH Contractor during an emergency or non-emergency behavioral health hospital admission, the portion of the hospital stay during which the Member was enrolled with the BH Contractor shall be paid by the BH Contractor at the rates agreed upon by the hospital and the BH Contractor provided that the hospital complies with the BH Contractor's service authorization and billing policies and procedures. The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-licensed bed; or at the transfer per diem rate for psychiatric services in a non-DMH-licensed bed; or for substance-related disorder services, capped at the Hospital-specific SPAD.

(5) Rates of payment for Administrative Days (AD)

(a) Subject to all other requirements and limitations stated herein, payments for Administrative Days will be made only when provided to Members under age 21 or to Members who are receiving services in a DMH-licensed bed.

(b) Payments for ADs will be made on a per diem basis. These per diem rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals. For RY06 the AD rates are $221.41 for Medicaid/Medicare Part B eligible patients and $239.42 for Medicaid-only patients. MassHealth rules and regulations do not allow a patient to be admitted at an AD status. Exceptions to this rule are outlined in the regulations of EOHHS. In most cases, therefore, ADs will follow an acute stay in the hospital.

(c) A hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the AD status to determine the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status. The hospital may only bill for one SPAD, covering 20 cumulative MassHealth non-managed care acute days, and then for outlier days as specified in 114.1 CMR 36.05(3).

(6) Rates of Payment for Psychiatric Services

(a) Rates for Psychiatric Services in DMH-Licensed Beds. Services provided to MassHealth Members in DMH-licensed beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive regional weighted average psychiatric per diem. This payment mechanism does not apply to cases in which psychiatric services are provided to Members enrolled with the BH Contractor or an MCO, except as set forth in EOHHS program regulations or contracts.

The regions used to develop the all-inclusive regional weighted average per diem correspond to the Psychiatric Health Services Areas established by MassHealth as published in the 2006 Acute Hospital RFA. The rates and regions are as follows:

REGION	RATE
1	$821.12
2	$617.60
3	$629.63
4	$681.59
5	$681.59
6	$608.57

(b) Change of Managed Care Status During a Behavioral Health Hospitalization. When a Medicaid member is enrolled with the BH Contractor during a non-

emergency or emergency behavioral health admission, the portion of the hospital stay during which the member is enrolled with the BH Contractor shall be paid by the BH contractor at the rates agreed upon by the hospital and the BH Contractor provided that the hospital complies with the BH Contractor's service authorization and billing procedures. The portion of the hospital stay during which the member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem for psychiatric services in a DMH-Licensed bed or at the transfer per diem rate for substance-related disorder services and for psychiatric services in a non-DMH-Licensed bed, capped at the hospital-specific SPAD.

(7) Payment for Unique Circumstances

(a) Sole Community Hospitals. DHCFP will determine if a hospital meets the criteria established in 114.1 CMR 36.02. In lieu of the standardized payment amount methodology described in 114.1 CMR 36.05(2)(b) the inpatient payment amount is equal to the sum of 95% of the hospital's FY03 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the hospital-specific RY06 pass-through amount per discharge and the capital amount per discharge calculated pursuant to 114.1 CMR 36.05(2)(c) and (d). Adjustments were made for casemix in accordance with the methodology described for casemix as stated in 114.1 CMR 36.05 (2) (b).

In addition, Sole Community Hospitals are eligible for outlier payments for patients whose length of stay during a single hospitalization exceeds 20 acute days, and are subject to the transfer payment provisions of 114.1 CMR 36.05(4).

(b) Specialty Hospitals and hospitals with Pediatric Specialty Units. EOHHS will determine whether a hospital meets the definition of a specialty hospital or hospital's with a pediatric specialty unit, as those terms are defined in 114.1 CMR 36.02. The inpatient payment amount for a specialty hospital and for pediatric specialty units is equal to the sum of 95% of the hospital's FY03 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the hospital-specific RY06 pass-through amount per discharge and the capital amount per discharge, calculated pursuant to 114.1 CMR 36.05(2)(c) and (d). Adjustments were made for casemix in accordance with the methodology described for casemix as stated in 114.1 CMR 36.05 (2) (b).

In addition, Specialty Hospitals are eligible for outlier payments for patients whose length of stay during a single hospitalization exceeds 20 acute days, and are subject to the transfer payment provisions of 114.1 CMR 36.05(4).

EOHHS shall pay pediatric specialty hospitals and pediatric specialty units 85% of the hospital's expenses for inpatient services, as determined by EOHHS, for children admitted to such hospitals and pediatric specialty units between October 1, 2005 and September 30, 2006, whose casemix acuity is greater than 5.0.

EOHHS will periodically reconcile with Pediatric Specialty Hospitals and Pediatric Specialty Units expenses and payments for such cases as determined by EOHHS in accordance with the Rate Year 2006 Acute Hospital RFA.

(c) Public Service Hospitals.

1. Inpatient Payment. The standard inpatient payment amount per discharge for Public Service and Hospitals shall be equal to the sum of: 95% of the hospital's FY03 cost per discharge capped at 200% of the statewide average payment amount, adjusted for casemix and inflation; and the hospital-specific RY06 pass-through amount per discharge and the capital amount per discharge. Adjustments were made for casemix in accordance with the methodology described for casemix as stated in 114.1 CMR 36.05 (2) (b).

In addition, Public Service Hospitals are eligible for outlier payments for patients whose length of stay during a single hospitalization exceeds 20 acute days, and are subject to the transfer payment provisions of 114.1 CMR 36.05(4).

Acute hospitals that receive payment as Public Service Hospitals shall be determined by EOHHS.

2. Supplemental Medicaid Rate for Public Service Hospitals. Subject to legislative appropriation or authorization, compliance with all legislative conditions compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and the availability of federal financial participation at the rate of no less than 50 percent.

EOHHS shall pay Public Service Hospitals a percentage of the difference between the qualifying Hospital's total Medicaid charges and total Medicaid payments for such charges, which percentage shall in no event exceed 100 percent. Alternatively, EOHHS reserves the right to make payments to Public Service Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Public Service Hospitals shall be determined by EOHHS.

(d) Essential MassHealth Hospitals.

1. Qualification. In order to qualify for payment as an Essential MassHealth Hospital, a hospital must meet at least four of the following criteria, as determined by EOHHS:

a. The hospital is a non-state-owned public acute hospital;

b. The hospital meets the current MassHealth definition of a non-profit teaching hospital affiliated with a Commonwealth-owned medical school;

c. The hospital has at least 7% of its total patient days as Medicaid days;

d. The hospital is an acute-care general hospital located in Massachusetts that provides medical, surgical, emergency and obstetrical services;

e. The hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

2. Payment Methodology. Subject to legislative appropriation or authorization, compliance with all legislative conditions, compliance with all applicable federal statutes, regulations, waiver provisions, and payment

limits, and the availability of federal financial participation at the rate of no less than 50 percent, EOHHS shall pay Essential MassHealth Hospitals a percentage of the difference between the qualifying hospital's total Medicaid charges and total Medicaid payments for such charges, which percentage shall in no event exceed 100 percent. Alternatively, EOHHS reserves the right to make payments to Essential MassHealth Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

(e) Freestanding Pediatric Acute Hospital's Rate Add On. Subject to legislative authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and federal financial participation at the rate of no less than 50 percent, EOHHS will make a supplemental payment equal to $5.79 million, in addition to the standard payment made under this regulation, to Freestanding Pediatric Acute Hospitals, to account for high Medicaid volume.

The payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the Hospital Rate Year.

Alternatively, EOHHS reserves the right to make payments to Freestanding Pediatric Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Freestanding Pediatric Acute Hospitals shall be determined by EOHHS.

(8) Rehabilitation Unit Services in Acute Hospitals.

(a) Applicability. A per diem rate for rehabilitation services provided at an acute hospital shall apply only to acute hospital rehabilitation units operating at Public Service Hospitals in order to meet any remaining service needs following the closure of a public rehabilitation hospital.

(b) Payment Method. The per diem rate for such rehabilitation services will equal the average MassHealth RY02 rehabilitation hospital rate, weighted by volume of days, after removing the two lowest-rate rehabilitation hospitals from the average, then updated by inflation factors for operating costs between RY02 and RY06. Acute hospital administrative day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care.

(9) Acute Hospitals with Proportionately High Medicaid Discharges.

(a) Applicability. Subject to legislative authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and federal financial participation at the rate of no less than 50 percent, EOHHS will make a supplemental payment, in addition to the standard payment made under 114.1 CMR 36.00 to Acute Hospitals with Proportionately High Medicaid Discharges, as determined by EOHHS.

(b) Payment Method. The payment amount will be a percentage of the difference between the qualifying Hospital's total Medicaid costs and total Medicaid

payments for such costs from any source, which percentage shall in no event exceed 100 percent. Alternatively, EOHHS reserves the right to make payments to Acute Hospitals with Proportionately High Medicaid Discharges in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Payments shall be subject to annual review to determine whether, in the Commonwealth's discretion, a supplemental payment is warranted to ensure adequate access and reasonable payment levels at the hospital. Acute Hospitals that qualify for payment as an Acute Hospital with Proportionately High Medicaid Discharges shall be determined by EOHHS.

36.06: Determination of Medicaid Outpatient and Emergency Department Payment Rates for Disproportionate Share Hospitals and Sole Community Hospitals

(1) Applicability.

(a) Except as otherwise provided in 114.1 CMR 36.01(4), 114.1 CMR 36.06 establishes Medicaid outpatient and emergency department rates of payment to acute care hospitals that are disproportionate share hospitals and sole community hospitals under M.G.L. 118G and that enter into an agreement with EOHHS for provision of acute hospital services to MassHealth members pursuant to the Acute Hospital Request for Applications. Disproportionate share hospital status is determined by the Division pursuant to 114.1 CMR 36.04.

(b) A hospital will be paid in accordance with 114.1 CMR 36.06 for outpatient services provided by hospital outpatient departments, HLHCs, and satellite clinics.

(c) Rates for outpatient services covered under a contract between the acute hospital and the Behavioral Health Contractor or MassHealth Managed Care Organization (BH MCO) that are provided to Medicaid patients eligible for or assigned to EOHHS's BH Contractor or MCO are governed by terms agreed upon between the acute hospital and the BH Contractor or MCO, as applicable.

(2) Payment Amount Per Episode (PAPE). Except for those outpatient services specified in 114.1 CMR 36.06(2)(f), hospitals will receive a hospital-specific episodic payment, known as the Payment Amount Per Episode (PAPE).

(a) Rate Development. Each Hospital's PAPE is the product of the outpatient statewide standard and the hospital's casemix index. The base year for the PAPE is RY04, paid as of July 12, 2005.

(b) Outpatient Statewide Standard. The RY06 outpatient statewide standard is $122.58. For PPS-exempt hospitals, the outpatient statewide standard is 130% of the outpatient statewide standard for non-PPS-exempt hospitals, which in RY06 is $159.36.

(c) Casemix Index. The hospital-specific casemix index is trended from casemix data from January 1, 2001 through September 30, 2004 to determine the average APG weight per episode. In every case, the hospital-specific average APG weight per episode is calculated for the relevant period by dividing the relevant payment by the conversion factor for the relevant period, and then by the number

of episodes. For the PAPE base year, the standard APG conversion factor was $118.77. The pediatric conversion factor was $124.06

(e) Payment System. MassHealth processes and pays clean outpatient claims in accordance with 130 CMR 450 *et seq.*

(f) Excluded Services. The following services are excluded from the PAPE payment system:

1. Physician Services. See 114.1 CMR 36.06(3).
2. Hospital Outpatient Services Payment Limitations. See 114.1 CMR 36.06(4).
3. Non-Emergency Services in Emergency Department. See 114.1 CMR 36.06(5).
4. Dental Services. Except when the conditions in EOHHS regulation 130 CMR 420.429(A) or (D) apply, see 114.1 CMR 36.06(7).
5. Other Services (in table):
   (a) Clinical Laboratory Services
   (b) Audiology Dispensing
   (c) Vision Care
   (d) Ambulance Services
   (e) Psychiatric Day Treatment Services
   (f) Adult Day Health Services
   (g) Early Intervention Services
   (h) Home Health Services
   (i) Adult Foster Care Services

(3) Physician Payments. A hospital may only receive payment for physician services provided by hospital-based physicians or hospital-based entities to MassHealth Members. The hospital must claim payment for the professional component of physician services in accordance with, and subject to: (1) the Physician Regulations at 130 CMR 433.000 et seq.; (2) the Acute Outpatient Hospital Regulations at 130 CMR 410.000 et seq.; and, (3) other rules regarding physician payment as set forth in the RFA.

(a) Such payment shall be the lower of: (1) the fee established in the most current promulgation of DHCFP regulations 114.3 CMR 16.00, 17.00 and 18.00 (including the applicable facility fee for all services where such facility fee has been established); (2) the hospital's usual and customary charge for physician fees; or, (3) the hospital's actual charge submitted. Hospitals will not be paid separately for professional fees for practitioners other than hospital-based physicians or hospital-based entities.

(b) Hospitals will be paid for physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the outpatient service(s) on the billed date(s) of service.

(c) Physician services provided by residents and interns are not paid separately.

(d) Hospitals will not be paid for physician services if those services are: provided by a Community-Based Physician or Community-Based Entity; or, as further described in 114.1 CMR 36.06 (7).

(4) Hospital Outpatient Services Payment Limitations.

(a) Payment Limitations on Hospital Outpatient Services Preceding an Admission. Hospitals will not be separately paid for hospital outpatient services when an inpatient admission to the same hospital, on the same date of service, occurs following the provision of hospital outpatient services; however, this payment limitation does not apply where an admission involving a one-day length of stay occurs on the same day following a surgical or other outpatient procedure, refer to 36.05(4)(b)3.

(b) Payment Limitations on Outpatient Services to Inpatients. Hospitals will not be paid for outpatient services provided to any Member who is concurrently an inpatient of any hospital. The hospital is responsible for payment to any other provider of services delivered to a Member while an inpatient of that hospital.

(5) Payment for Non-Emergency Services in Emergency Department.

(a) Required Screening. All Members presenting in the emergency department or dedicated emergency department as defined in 42 CFR 489.24 must be screened and stabilized in accordance with applicable requirements at 42 U.S.C. 1396dd et seq. and M.G.L. c.118E, section 17A and all applicable regulations.

(b) Payment for Emergency Services. Hospitals will be paid for emergency services provided in the emergency department in the same manner as other outpatient services.

(c) Payment for Non-Emergency Services in the Emergency Department. Except as provided in 114.1 CMR 36.06 (5)(d) below, the emergency department facility screening fee of $62.47 is the exclusive payment for hospitals providing non-emergency services in the emergency department.

(d) Hospitals will not be paid an Emergency Department facility screening fee when the hospital bills a PAPE for the patient for the same date of service.

(e) Physician Payment. In addition to the emergency department screening fee described in 114.1 CMR 36.06 (5)(c), when a hospital-based physician or a hospital-based entity provides physician services in the course of providing non-emergency services in the emergency department, the hospital may be paid an additional professional screening fee in accordance with 114.3 CMR 16.00, 17.00, and 18.00.

(6) Dental Services. All covered dental services will be paid by EOHHS, subject to all applicable regulations at 130 CMR 420.000 et seq. at the lower of the most current rates promulgated by the DHCFP as established in 114.3 CMR 14.00 et seq., or the hospital's usual and customary charge, except when the conditions in 130 CMR 420.429(A) or (D), 420.439, or 420.449(A) apply. When these conditions apply, EOHHS will pay the hospital according to 114.1 CMR 36.06(2).

(a) Physician Payment. Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of dental services, except when the conditions in 130 CMR 420.429(A) or (D) apply. Under those circumstances, in addition to the PAPE payment under 114.1 CMR 36.06(2), when a hospital-based physician or hospital-based entity provides physician services, the hospital may be paid for such physician services in accordance with 114.1 CMR 36.06 (3).

(b) Payment Rates for HLHCs. A hospital that operates one or more hospital-licensed health centers (HLHCs) under its license may receive a dental enhancement fee for MassHealth-covered dental services provided, in accordance with 130 CMR 420 et seq. and 130 CMR 405.410, and 114.3 CMR 4.05(1). In order to receive the dental enhancement fee, the hospital must submit to MassHealth an executed HLHC Dental Partnering Project Agreement and comply with the terms set forth therein. Only those HLHCs that the hospital identifies in the HLHC Dental Partnering Project Agreement are eligible for the dental enhancement fee.

(7) Other Services.

Regulation Title	**Payment will be lower of hospital's usual and customary charge or the rates set forth in:**	**Will hospital be paid for hospital-based physician or hospital-based entity physician services related to provision of service?**	**Additional stipulations**
Laboratory Services	114.3 CMR 20.00 and 16.00 et seq.; or, the amount that would be recognized under 42 U.S.C. §13951(h) for tests performed for a person with Medicare Part B benefits.	No, except for surgical pathology services. The maximum allowable payment is payment in full for the laboratory service.	
Audiology Dispensing	114.3 CMR 23.00	No.	Hospitals will be paid for the dispensing of hearing aides only by a hospital-based audiologist, according to the Audiologist Regulations at 130 CMR 426.000 et seq.
Vision Care	114.3 CMR 15.00	No.	Hospitals will be paid for the dispensing of ophthalmic materials only by a hospital-based optometrist, ophthalmologist, or other practitioner licensed and authorized to write prescriptions for ophthalmic materials and services according to the Vision Care Regulations at 130 CMR 402.000 et seq.
Ambulance Services	114.3 CMR 27.00 et seq.	No.	Ambulance services shall be classified as either air or ground ambulance services. If the costs of the ground ambulance services were included by the hospital in the FY03 cost report for outpatient hospital services, no additional reimbursement may be billed for ground service ambulance. In order

			to receive payment for air ambulance services, hospitals must have separate contracts with EOHHS for such services.
Psychiatric Day Treatment Services	114.3 CMR 7.03 et seq.	No.	Hospitals are not paid for psychiatric day treatment services in addition to outpatient mental health services if both were delivered on the same day. In order to qualify for payment, the psychiatric day treatment program must be certified by MassHealth.
Adult Day Health Services	114.3 CMR 10.00 et seq.	Yes.	
Early Intervention Services	114.3 CMR 49.00 et seq.	Yes.	
Home Health Services	114.3 CMR 3.00 et seq.	Yes.	
Adult Foster Care Services	The rates developed by EOHHS.	Yes.	

36.07: Safety Net Care Acute Hospital Payments Under the MassHealth 1115 Demonstration

(1) Overview.

(a) Applicability. The Medicaid program assists hospitals that carry a financial burden of caring for the uninsured and publicly-insured persons of the Commonwealth. In accordance with the terms and conditions of the Commonwealth's 1115 waiver governing the Safety Net Care Pool, and subject to compliance with all applicable federal requirements, MassHealth will make an additional payment adjustment above the rates established under 114.1 CMR 36.05 and 114.1 CMR 36.06 to hospitals that qualify for such payment under any one or more of the following classifications.

(b) Eligibility. Only hospitals that have an executed contract with EOHHS pursuant to the RY06 RFA are eligible for the following Safety Net Care payments. Eligibility requirements for each type of Safety Net Care payments and the methodology for calculating those payments are described in 114.1 CMR 36.07. When a hospital applies to participate in MassHealth, its eligibility and the amount of the Safety Net Care payments shall be determined. As new hospitals apply to become MassHealth providers, they may qualify for such payments if they meet the criteria under one or more of the following classifications (114.1 CMR 36.07). If a hospital's Medicaid contract is terminated, its payment shall be prorated for the portion of RY06 during which it had such contract with EOHHS, the remaining funds it would have received shall be apportioned to remaining eligible hospitals.

This means that some Safety Net Care Pool payments may require recalculation. Hospitals will be informed if the payment will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by EOHHS will be handled at that time. All Safety Net Care payments are subject to the availability of federal financial participation.

(2) High Public-Payer Hospitals

(a) Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.04 are eligible for the adjustment in 114.1 CMR 36.07(2)(b).

(b) Calculation of Adjustment.

1. EOHHS allocates $11.7 million for this payment adjustment.

2. The Division then calculates for each eligible hospital the ratio of its allowable free care charges, as defined in M.G.L. c. 118G, to total charges. The Division will obtain free care charge data from the hospitals UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).

3. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.07(2)(b)2.

4. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.07(2)(b)2.

5. Hospitals that meet or exceed the 75th percentile qualify for a High Public-Payer Hospital payment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.6 CMR 11.04 to determine allowable free care costs.

6. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(2)(b)5 for all hospitals that qualify for a High Public-Payer payment.

7. Each eligible hospital's High Public-Payer Hospital payment is equal the amount allocated in 114.1 CMR 36.07(2)(b)1 multiplied by the amount determined in 114.1 CMR 36.07(2)(b)5 and divided by the amount determined in 114.1 CMR 36.07(2)(b)6.

(3) Basic Safety Net Care Payment

(a). The Division determines a Basic Safety Net Care Payment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the Basic Safety Net Payment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

1. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form.

2. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

(b). The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the Basic Safety Net Care Payment. The Division determines such threshold as follows:

1. First, the statewide weighted average Medicaid inpatient utilization rate is calculated. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.
2. Second, the statewide weighted standard deviation for Medicaid inpatient utilization statistics is calculated.
3. Third, the statewide weighted standard deviation for Medicaid inpatient utilization is added to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.
4. Lastly, each hospital's Medicaid inpatient utilization rate is calculated by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3, then the hospital is eligible for the Basic Safety Net Care Payment under the Medicaid utilization method.

(c). The Division then calculates each hospital's low-income utilization rate as follows:

1. First, the Medicaid and subsidy share of gross revenues is calculated as follows:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

2. Second, the free care percentage of total inpatient charges is calculated by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.
3. Third, the low-income utilization rate is calculated by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(3)(c)1 to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(3)(c)2. If the low-income utilization rate exceeds 25%, the hospital is eligible for the Basic Safety Net Care Payment under the low-income utilization rate method.

(d). Payment Methodology. The payment under the Basic Safety Net Care Payment is calculated as follows:

1. For each hospital determined eligible for the Basic Safety Net Care Payment under the Medicaid utilization method established in 114.1 CMR 36.07(3), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)4 by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3. The resulting ratio is the Basic Medicaid ratio.

2. For each hospital determined eligible for the Basic Safety Net Care Payment under the low-income utilization rate method, but not found to be eligible for the Basic Safety Net Care Payment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The resulting ratio is the Basic Medicaid ratio.

3. The Division then determines, for the group of all eligible hospitals, the sum of Basic Medicaid ratios calculated pursuant to 114.1 CMR 36.07(3)(d)1. and 114.1 CMR 36.07(3)(d)2.

4. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(3)(e) by the sum of the Basic Medicaid ratios calculated pursuant to 114.1 CMR 36.07(3)(d)3.

5. The Division then multiplies the minimum payment by the Basic Medicaid ratio established for each hospital pursuant to 114.1 CMR 36.07(3)(d)1 and 2. The product is the payment under the Basic Safety Net Care Payment method. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean.

(e). The total amount of funds allocated for payment to acute care hospitals under the Basic Safety Net Care method is $200,000 per year. These amounts are paid by EOHHS, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(3)(d)5.

(4) Public Service Hospital Safety Net Care Payment. The Division determines Public Service Hospital Safety Net Care Payments using the data and methodology described in 114.1 CMR 36.07(4).

(a) Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC report and total charges from the DHCFP-403. If the specified data source is unavailable, then the unreimbursed costs are calculated using the best alternative data available.

(b) Eligibility for the Public Service Hospital Safety Net Care Payment. The Public Service Hospital Safety Net Care Payment is a payment for any hospital that:

1. is a public or public-service hospital as defined in 114.1 CMR 36.02;

2. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by DHCFP that is at least 15% of its total charges; and

3. is an essential safety-net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients.

(c) Public Service Hospital Safety Net Care Payment Method.

1. The payment amount shall be reasonably related to the costs of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients.

2. The payment shall be based on an agreement between EOHHS and the qualifying hospital. EOHHS shall make a Public Service Hospital Safety Net Care payment to a qualifying hospital; provided that such payment shall be adjusted if necessary, to ensure that such payment does not exceed (a) 100% of such hospital's total unreimbursed free care and unreimbursed Medicaid

costs for the same fiscal year. Such unreimbursed costs shall be calculated by EOHHS using the best data available, as determined by EOHHS for the fiscal year.

3. Alternatively, EOHHS reserves the right to make Public Service Hospital Safety Net Care payments in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

4. The payment of the safety net adjustment to a qualifying hospital in any rate year shall be contingent upon the continued availability of federal financing participation for such payments.

(5) Uncompensated Care Safety Net Care Payment. Hospitals eligible for this payment are those that report free care costs, as defined by 114.6 CMR 11.00, and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 11.00. These payments are made to eligible hospitals in accordance with the Division's regulations and the interagency service agreement (ISA) between EOHHS and DHCFP. Eligible hospitals receive these payments on a periodic basis during the term of their RY06 hospital contract with EOHHS.

(6) Public Health Substance Abuse Safety Net Care Payment. Hospitals eligible for this payment are those acute facilities that provide hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000, as limited in DPH's ISA with EOHHS. The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 and DPH's ISA with EOHHS.

(7) Safety Net Care Payments for Pediatric Specialty Hospitals and Units**.**

Eligibility. In order to be eligible for this adjustment, the hospital must meet the definition of a Pediatric Specialty Hospital or Unit as defined in 114.1 CMR 36.02. In addition, the hospital must have a signed contract with EOHHS for the period that such adjustment is in effect.

(a) Methodology. The Division will calculate an adjustment as follows:

1. For each eligible hospital, the Division will calculate the ratio of MassHealth pediatric days to the total MassHealth pediatric days for all eligible hospitals.

2. The Division will multiply the ratio calculated in 114.3 CMR 36.07(7)(b)(1) by the total allocation cited in 114.3 CMR 36.07(7)(c) to determine the payment amount for each hospital.

3. This payment will reimburse only those costs that have not otherwise been paid and will be paid subject to the availability of federal financial participation.

(c) Payment Amount. The total amount of funds allocated for payment to hospitals will be the amount appropriated for such. These amounts are determined pursuant to 114.1 CMR 36.07(7)(b). Payments are made by EOHHS and distributed among eligible hospitals determined pursuant to 114.1 CMR 36.07(7)(a).

36.08: Medicaid Rates of Payment for Emergency Services at Hospitals that Do Not Contract with EOHHS Pursuant to the RFA

(1) Overview: 36.08 establishes rates of payment to acute care hospitals who have not signed a contract with EOHHS pursuant to the RFA. Rates of payment for all emergency services and continuing emergency care provided in an acute hospital to medical assistance program members, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395 (dd) are as follows:

(2) Payment for emergency inpatient admissions is made using the transfer *per diem* rate of payment, established according to the methodology set forth in 114.1 CMR 36.05(4), up to the hospital-specific standard payment amount per discharge, established according to the methodology set forth in 114.1 CMR 36.05(2)(c). If the data sources specified in 114.1 CMR 36.05(9) are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.05, the Division will select such substitute data sources that the Division determines appropriate in determining hospitals' rates. Hospitals must notify EOHHS within 24 hours of admitting a Medicaid beneficiary in order to be eligible for payment pursuant to 114.1 CMR 36.08.

(3) Rates of payment for emergency outpatient services provided in a hospital emergency department, outpatient department, or hospital-licensed heath center will be paid at the rates established at 114.1 CMR 36.06.

(4) Rates of payment for outpatient emergency services provided by a hospital-based physician are established according to the methodology set forth in 114.1 CMR 36.06(12).

(5) Rates of payment for services provided by a hospital-based physician to a patient admitted as an inpatient in an emergency situation will be paid according to the methodology set forth at 114.1 CMR 36.05(2)(i).

36.09: Upper Limit

Medicaid rates of payment calculated under the provisions of 114.1 CMR 36.05 conform to the upper limit requirement imposed by Title XIX of the Social Security Act, which requires that states certify that hospital payments in the aggregate do not exceed the amount of payments that would result if payments were based on the Medicare payment principles. Rates of payment established pursuant 114.1 CMR 36.00 may be adjusted if it is determined that aggregate payments exceed this limit or if adjustments are required by the Centers for Medicare and Medicaid Services (CMS). Such adjustments may be made on either a prospective or retrospective basis.

(1) FFP Denials. If any portion of the payment pursuant to 114.1 CMR 36.00 is not approved or is the basis of a disallowance by CMS, EOHHS may recoup, or offset against future payments, any payment made to a hospital in excess of the approved payment.

(2) Exceeding Limits.

(a) Hospital-Specific Limits. If any payments made pursuant to 114.1 CMR 36.00 exceed federal hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and limits based on federally approved payment methods, EOHHS may recoup, or offset against future payments, any payment made to a Hospital in excess of the applicable limit.

(b) Aggregate Limits. If any payments made pursuant to 114.1 CMR 36.00 exceed applicable federal aggregate payment limits, including, but not limited to upper payment limits provided for in federal law, regulations and the Commonwealth's 1115 waiver, EOHHS may exercise its discretion to apportion the disallowance among the affected hospitals and to recoup from, or offset against future payments to such hospitals, or to otherwise restructure payments in accordance with approved payment methods.

36.10: Hospital Mergers and New Hospitals

(1) Hospital Mergers. For any hospital that is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership, or operation of the hospital during the fiscal year, the Division may make adjustments to the hospitals' rates. The Division will determine the best available data source(s) for these adjustments.

(2) New Hospitals. The rates of payment for new hospitals shall be determined in accordance with the provisions of 114.1 CMR 36.00 to the extent the Division deems possible. If the data sources specified in 114.1 CMR 36.07 are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.07, the Division will select such substitute data sources that the Division deems appropriate in determining hospitals' rates.

36.11: Administrative Adjustment

(1) If, at its own initiative, the Division concludes that an error has been made in a determination made pursuant to 114.1 CMR 36.00, it may correct such error.

(2) A hospital may apply for an administrative adjustment if the hospital believes an arithmetic, mechanical, or clerical error exists in a determination made pursuant to 114.1 CMR 36.00. The Division will not entertain a request for an administrative adjustment if the hospital is seeking to reverse a substantive determination pursuant to 114.1 CMR 36.00. The request for administrative adjustment must be received at the Division within 20 business days of the date of notification of the Division's determination. The request must be in writing and contain a precise explanation of the perceived error as well as any documentation to support the request.

(3) In the event that, during a contract year, a hospital opens or closes an inpatient service that the hospital believes will have a significant effect on casemix, the hospital must provide EOHHS with a data analysis of the casemix effect if it requests a casemix adjustment. EOHHS may, in its sole discretion, consider revised data submitted by the hospital.

36.12: Penalties

An acute care hospital that makes a charge or accepts payment based upon a charge in excess of that filed with the Division or which fails to file any data, statistics, schedules, or other information pursuant to 114.1 CMR 36.00 or which falsifies same, shall be subject to a civil penalty of not more than $1000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.1 CMR 36.00.

36.13: Severability

The provisions of 114.1 CMR 36.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any of the remaining provisions of 114.1 CMR 36.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.1 CMR 36.00: M.G.L. 118G, and St. 1991, c. 495.